Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

PHYSICAL THERAPISTS AFFILIATED CREDENTIALING BOARD

APPLICATION FOR LICENSE TO PRACTICE PHYSICAL THERAPY

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK ☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth
_____ _____ _____
month day year

Daytime Telephone Number
( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? _____Yes _____No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

School Name: _____

School Address: _____
(City) (State) (Country)

Date Diploma Granted: _____
month/day/year

Degree: _____ **Specialty:** _____

BOARD OFFICE USE ONLY
Temporary Permit Requested: _____Yes _____ No

APPLICATION FEES Please check applicable blank: Make check payable to the Department of Regulation and Licensing & attach to this application.

For Receipting Use Only

_____ **NPTE & State Law**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 15.00 Contract Exam Fee
$125.00 Total Fee Attached

NPTE Exam and Fee (must apply directly to FSBPT at **www.fsbpt.net/pt**)

____ **Request for a Temporary License** (exam candidate only)
$ 10.00 Is required in addition to the above fee (*non-refundable*)

_____ **Endorsement of NPTE**
(From FSBPT)
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$110.00 Total Fee Attached

_____ **Reciprocity by Old State Board Exam.** (Prior to 1969)*
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$119.00 Total Fee Attached

ORAL EXAMINATION: $266.00

If you should be selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for the exam

#578 (Rev. 5/09)
Ch. 448, Stats.

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APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Certificate of Professional Education *(Form #1486).*

Fee(s) attached to this application.

NPTE Form and fee filed with FSBPT *(NPTE candidates only)*

Scores for TOEFL, TWE and TSE *(foreign trained only)*

Wisconsin Statutes & Rules exam

National Physical Therapist Assistant Examination Scores *(must be sent directly from FSBPT)*

Letters from all State Boards where licensed *(includes active and inactive licenses).*

Copies of malpractice suit(s).

Completed Education Evaluation Report from a Board approved evaluation service *(foreign trained only)*

Submit proof of completion of at least 30 hours of continuing education approved by the board that were taken 2 years prior to your application. (For Endorsement candidates only)

PRACTICE: Account for all activities and practice from date of graduation to the present time. **Must include professional and nonprofessional activities. ALL dates and time must be accounted for.**

	LOCATION EMPLOYER NAME, CITY, STATE & COUNTRY	**DATES (from - to) MO/YR**	**# OF HOURS PER WEEK**	**JOB TITLE & DUTIES**
1.				
2.				
3.				
4.				

I AM CREDENTIALED IN THE FOLLOWING STATES (UNLIMITED):

By Written Exam: _____

By Endorsement/Reciprocity: _____

Submit proof of completion of at least 30 hours of continuing education approved by the board that were taken 2 years prior to your application. (For Endorsement candidates only)

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN PHYSICAL THERAPISTS AFFILIATED CREDENTIALING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, CREDENTIAL NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE.

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

		YES	NO
1.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	❑	❑
2.	Have you ever surrendered, resigned, canceled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	❑	❑
3.	Have you ever failed to pass any state board examination, national board examination, or NPTE examination? If yes, give details on an attached sheet.	❑	❑

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		YES	NO
4.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	❑	❑
5.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	❑	❑
6.	Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)	❑	❑
7.	Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)	❑	❑
8.	Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	❑	❑
9.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	❑	❑
10.	Have your privileges ever been limited or removed? If yes, give details on an attached sheet.	❑	❑
11.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	❑	❑
12.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	❑	❑

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice physical therapy" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned physical therapy judgments and to learn and keep abreast of physical therapy developments; and

2. The ability to communicate those judgments and physical therapy information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform physical therapy tasks such as examination and treatment procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
13.	Do you have a medical condition which in any way impairs or limits your ability to practice physical therapy with reasonable skill and safety? If yes, please explain.	❑	❑
14.	Does your use of chemical substance(s) in any way impair or limit your ability to practice physical therapy with reasonable skill and safety? If yes, please explain.	❑	❑
15.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	❑	❑
16.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	❑	❑
17.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	❑	❑
18.	Are you currently engaged in the illegal use of controlled dangerous substances?	❑	❑
19.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	❑	❑

CERTIFICATION OF LEGAL STATUS.

I declare under penalty of law that I am (check one):

_____ a citizen or national of the United States, or

_____ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

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ALL APPLICANTS MUST COMPLETE THIS SECTION

AFFIDAVIT OF APPLICANT
(Sign and date <u>in the presence of</u> a notary)

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

_____ _____
Signature of Applicant Date

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____
Signature of Notary Public

S E A L

_____
Date Commission Expires

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SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name Middle Initial Last Name

_____

Profession

Date of Birth _____ _____ _____

month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.

[2] Sections 49.22, and 440.13, Wis. Stats.

[3] Section 440.12, Wis. Stats.

[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.